

Relations between Season of Birth and Subsequent Seasons

Periods	Calendar Months of Birth	No. of Months Exposed to:	
		Winter Conditions (Oct.-March)*	Summer Conditions Apr.-September)*
Neonatal	January-June	3	3
	July-December	3	3
	April-September	—	6
	October-March	6	—
1-5 months	January-June	6	24
	July-December	24	6
	April-September	15	15
	October-March	15	15
6-11 months	January-June	27	9
	July-December	9	27
	April-September	15	21
	October-March	21	15

*Northern Hemisphere only.

between 1 and 6 months than children who are born in other seasons (see table); and (b) because respiratory infections are twice as common in winter as in summer and cause twice as many deaths between 1 and 6 months as during the rest of infancy.²

The first study revealed a deficit of childhood leukaemias among the O.S.C.C. twins who were not x-rayed before birth which affected like-sex twins (60% deficit) more than opposite-sex twins (30%);³ also second deliveries (62%) more than first deliveries (34%).⁴

In the second (unpublished) study⁴ the O.S.C.C. cases were compared with children whose deaths were either unexpected and unexplained (cot deaths) or were ascribed to pulmonary infections. The relevant findings relate to deaths within six months of birth because this is the period most affected by the switch from passive to active immunity and also the period when the risk of an infection death is most strongly influenced by season of birth (see table). Among the cancer deaths in this age range there was a deficit of births in the second half of the year which affected leukaemias (54% deficit) and lymphomas (46%) far more than other cancers (3%). And among the other deaths there was a deficit of births during the first half of the year which affected the unexplained deaths (47%) more than the deaths which were obviously caused by infections (35%).

Finally, the unpublished O.S.C.C. data⁴ showed that there was a rapid replacement of myeloid by lymphatic leukaemias after the second month of life. For deaths within two months of birth the myeloid to lymphatic ratio was 3.50; for deaths between two and six months the ratio was 0.69; and for later deaths it was 0.41.

To sum up, it clearly requires more than epidemiological data to establish the existence of a group of haemopoietic neoplasms which are associated with such profound disturbances of the reticuloendothelial system as to be causes of unexpected and unexplained stillbirths and infant deaths. There are, however, indications that myeloid leukaemia has remained a rare cause of childhood deaths only because cases with embryonic origins are exceptionally difficult to recognize; also indications that it is only during the period when passive immunity is operative that there is any relaxation of these diagnostic difficulties.—I am, etc.,

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² Registrar General's Statistical Review for England and Wales for 1970, Tables, pt. I Medical. London, H.M.S.O., 1972.

³ Stewart, A. M., *British Journal of Cancer*, 1973, 27, 465.

⁴ Oxford Survey, U.S. Public Health Service and the Medical Research Council. Unpublished data.

Septic Abortion and the Dalkon Shield

SIR,—The Dalkon Shield intrauterine device has now been on the market in the U.K. for approximately three years and for one year longer in the U.S.A. and up to the present time approximately 2½m. insertions have taken place.

Recently it has come to the attention of my parent company in the U.S.A. that there has been an apparent increase in the number of cases of septic abortions, many mid-trimester in timing, occurring in patients purportedly wearing the Dalkon Shield. Four fatalities have been reported but there is no evidence of a direct cause-and-effect relationship between the wearing of the Dalkon Shield and the occurrence of septicemia. I am certain that the apparent increase is due more to the increased number of physicians and women who prefer this method of contraception than to any inherent fault in the Dalkon Shield itself.

We are of course exploring every reasonable approach to determine whether any unique relationship exists between the Dalkon Shield and septic abortions and in this connexion I would be most grateful if any cases which occur in patients could be reported to me with as full details as possible. In the meantime I feel that the following precautionary steps should be followed in the management of patients:

(1) Every patient who misses a menstrual period should have a pregnancy test.

(2) As soon as a pregnancy is confirmed the device should be removed if it is possible to do so by traction with the string.

(3) If the device cannot be so readily removed serious consideration should be given to offering the patient a therapeutic abortion.

(4) If the pregnancy is allowed to continue, whether or not the device is removed, the patient should be followed very closely for early signs which will alert the physician to potential severe complications.

It is suggested that all patients in whom a Dalkon Shield is considered for contraceptive purposes, should be advised prior to insertion that a therapeutic abortion may be recommended in the event of an accidental pregnancy.—I am, etc.,

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Can I Have an Ambulance, Doctor?

SIR,—Dr. D. E. Ford (4 May, p. 278) suggests, on the basis of our paper (9 February, p. 226) that outpatient physiotherapy at Northwick Park Hospital is likely to be ineffective because of its infrequency. This raises several points.

First of all, this was not physiotherapy at Northwick Park Hospital, but was in fact physiotherapy at the Harrow Physical Treatment Centre. Because we had the opportunity to take over this unit for a short time before the opening of the physiotherapy department at Northwick Park Hospital, it seemed to us to be an excellent opportunity to carry out a number of surveys.

Secondly, of course, we were referring to the minority (12% of patients) who require ambulance transport. These tend to be the elderly (50% were over the age of 65).

A further point is that it has never been convincingly demonstrated that the presumed effectiveness of physiotherapy depends upon its frequency of application by the therapist. On the contrary, in an ongoing trial concerning the value of outpatients with strokes this appears to be not so. Well-instructed patients who do not attend the department seem to be doing at least as well as those who are attending five whole days per week.

Until Dr. Ford and his colleagues have demonstrated the comparative value of his basic 47-hour week (37 hours in the department and 10 travelling), despite the resultant social inconvenience, we would prefer to emphasize the teaching role of the physiotherapist at the present for this type of patient.—We are, etc.,

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Assessment of Surgical Treatment

SIR,—Your leading article "Do We Know What We Are Doing?" (13 April, p. 73) on the supposed continuing difference between physicians and surgeons was at least more restrained than the American article to which it referred.¹ Cast more in the style of a hospital pantomime than in the language of a scientific journal this asserted that there was a double standard, both in practice and in clinical journals, in regard to the assessment of medical as distinct from surgical treatment. But is the distinction really as clear-cut as that?

In medically developed countries well-balanced teams of physicians and surgeons are now the rule, at least where major specialist enterprises are being undertaken. I have recently pointed out that the physicians in such teams are often the enthusiasts who are pressing reluctant surgeons to operate.² Surgeons deserve sympathy rather than scolding, because their position is peculiarly difficult. They are exposed to pressure for action from both colleagues and patients; any surgical operation is still a dramatic experience for the individual who undergoes it, and patients naturally cherish high expectations of its result. In spite of these difficulties academic surgeons of standing frequently undertake controlled trials when the value of an

¹ Kneale, G. W., *British Journal of Preventive and Social Medicine*, 1971, 25, 152.